FACIAL TREATMENT
Consultation Form

Client Information:

Name: _____ Date of birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Occupation: _____

Emergency Contact Name: _____ Phone: _____

How did you hear about us? _____

Would you like to be added to our email list for specials and discounts? ◯ **Yes** ◯ **No**

Medical History:

Do you have or had any of these following conditions? If yes please check below.

- ◯ Acne
- ◯ Arthritis
- ◯ Asthma
- ◯ Blood disorder
- ◯ Cancer/Chemotherapy
- ◯ Cardio/Vascular Issues
- ◯ Dermatitis
- ◯ Diabetes
- ◯ Depression
- ◯ Easily Bruised/Sensitive Skin
- ◯ Eczema
- ◯ Epilepsy/Seizures
- ◯ Fatigue
- ◯ Fever blisters
- ◯ Fungal Condition
- ◯ Headaches/Migraines
- ◯ Heart condition
- ◯ Herpes
- ◯ Hepatits
- ◯ High blood pressure
- ◯ HIV/AIDS
- ◯ Hyper pigmentation
- ◯ Hypo pigmentation
- ◯ Hysterectomy
- ◯ Immune disorders
- ◯ Insomnia
- ◯ Keloid scarring
- ◯ Loss of Sensation
- ◯ Low blood pressure
- ◯ Lupus
- ◯ Organ Failure
- ◯ Metal bone pins/plates
- ◯ Phlebitis, blood clots
- ◯ Pregnant/Breast Feeding
- ◯ Seizure disorder
- ◯ Skin disease/lesions
- ◯ Seborrhoea
- ◯ Transplant
- ◯ Thyroid condition
- ◯ Varicose veins
- ◯ Warts
- ◯ Other _____

Any other conditions: _____

Any known allergies? ◯ Yes ◯ No: _____

List any medications you take regularly including vitamins, herbal supplements, aspirin:

_____

Any recent surgery, including plastic surgery? ◯ Yes ◯ No: _____

Are you pregnant or trying to become pregnant? ◯ Yes ◯ No

Do you smoke or consume alcohol? ◯ Yes ◯ No

Facial Consultation Form

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Skin Care History:

Please check current products you use.

- Eye Make-Up Remover
- Cleansing Cream
- Facial Soap
- Skin Toner/Astringent
- Body Soap
- Eye Cream
- Day Cream
- Night Cream
- Neck lotion
- Hand Cream
- Mask
- Facial Scrub
- Exfoliants
- Body Lotion
- Body Scrub

Skin History:

What is your skin type?	Normal	Oily	Dry	Combo
Your exposure to the sun?	Never	Light	Moderate	Excessive
Type of foundation you wear	Liquid	Cream	Powder	None
How does your skin heal?	Fast	Slow	Scars	Pigment
Do you get brusises easily	Yes	No		

Have you ever had a facial treatment before? ◯ Yes ◯ No

If yes, please explain: _____

What would you like to achieve from your treatment today? _____

_____

Have you ever used acne medication?: ◯ Yes ◯ No:

If yes, when?:_____ Which drug?: _____

Have you in the last 3 months used Retin-A, Renova, AHA's or Retinol/Vitamin A derivative products?

◯ No ◯ Yes, please explain:_____

Have you received Botox, Restylane, or Collagen injection in the last six months?

◯ No ◯ Yes, please explain:_____

Skin Concerns:

- Acne
- Blackheads
- Broken Capillaries
- Comedones
- Cherry Angioma
- Discoloration
- Dryness/Dull Skin
- Eczema
- Fine lines/Wrinkles
- Hyperpigmentation
- Hypopigmentation
- Keloids
- Milla
- Oily Skin
- Psoriasis
- Redness
- Rosacea
- Scarring
- Sensitivity
- Sun damage
- Thin
- Unwanted hair
- Other _____

By signing below, you agree to the following:
I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health history

Client Signature: _____ Client Printed: _____ Date: _____

Esthetician Signature: _____ Esthetician Printed: _____ Date: _____